Stonebridge Pediatrics

Submit By E-mail | Print Form

# Initial History Questionnaire

Patient Name: _____ DOB: _____

NOTE: Please complete a separate form for each child you are registering with our practice.

## Household

Please list all those living in the patient's home.

| Name | Relationship to Patient | Date of Birth | Health Problems? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are there other siblings not living in the home? If yes, please list their names, ages and where they live. _____

If mother & father are not living in the home, how often does s/he see the parent(s) not in the home? _____

If one or both parents are not living in the home, how often does s/he see the parent(s) not in the home? _____

## Birth History

Birth Weight: _____ pounds _____ ounces Birth Hospital Name: _____

Was the delivery ☐ Vaginal? ☐ Cesarean? If Cesarean, why? _____

Was the baby born ☐ Full-term? ☐ Pre-term? ☐ Post-term? If pre- or post-term, how many weeks gestation? _____

Did mother have any illnesses/problems with pregnancy? ☐ Y ☐ N Explain: _____

Did your baby have any problems after birth? ☐ Y ☐ N Explain: _____

Did baby go home with mother from the hospital? ☐ Y ☐ N Explain: _____

During pregnancy did mother ☐ smoke? ☐ drink? ☐ use street drugs? ☐ take prescription medications?

Please list all medications mother took during pregnancy: _____

## General

Do you consider your child to be in good health? ☐ Y ☐ N Explain: _____

Does your child have any serious illnesses or medical conditions? ☐ Y ☐ N Explain: _____

Has your child had any serious accidents? ☐ Y ☐ N Explain: _____

Has your child had any surgery or been hospitalized? ☐ Y ☐ N Explain: _____

Is your child allergic to any medicines or drugs? ☐ Y ☐ N Explain: _____

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# Development

| | | | | |
|---|---|---|---|---|
| Are you concerned about your child's physical development? | ☐ Y | ☐ N | Explain: | |
| Are you concerned about your child's emotional development? | ☐ Y | ☐ N | Explain: | |
| Are you concerned about your child's attention span? | ☐ Y | ☐ N | Explain: | |

For those children who attend school (this section may be skipped if your child is not in school):

| | | | | |
|---|---|---|---|---|
| Are you concerned about your child's behavior in school? | ☐ Y | ☐ N | Explain: | |
| Are you concerned about your child's academic progress? | ☐ Y | ☐ N | Explain: | |
| Has your child ever been repeated a grade? | ☐ Y | ☐ N | Explain: | |
| Does your child attend special education classes? | ☐ Y | ☐ N | Explain: | |

# Medical

Does your child have or has s/he ever had:

| | | | | |
|---|---|---|---|---|
| Chickenpox | ☐ Y | ☐ N | Explain: | |
| Frequent ear infections | ☐ Y | ☐ N | Explain: | |
| Problems with ears/hearing or eyes/vision | ☐ Y | ☐ N | Explain: | |
| Nasal allergies | ☐ Y | ☐ N | Explain: | |
| Asthma, bronchitis, bronchioloitis, or pneumonia | ☐ Y | ☐ N | Explain: | |
| Heart problems or heart murmur | ☐ Y | ☐ N | Explain: | |
| Anemia, bleeding problem, or blood transfusion | ☐ Y | ☐ N | Explain: | |
| Frequent abdominal pain | ☐ Y | ☐ N | Explain: | |
| Constipation | ☐ Y | ☐ N | Explain: | |
| Urinary tract infections | ☐ Y | ☐ N | Explain: | |
| Bedwetting (after age 7) | ☐ Y | ☐ N | Explain: | |
| (For girls) Has she started menstrual periods? | ☐ Y | ☐ N | Explain: | |
| (For girls) Are their problems with her menstrual periods? | ☐ Y | ☐ N | Explain: | |
| Chronic skin problems (i.e. eczema) | ☐ Y | ☐ N | Explain: | |
| Frequent headaches | ☐ Y | ☐ N | Explain: | |
| Epilepsy or convulsions | ☐ Y | ☐ N | Explain: | |
| Diabetes | ☐ Y | ☐ N | Explain: | |
| Thyroid or other endocrine problem | ☐ Y | ☐ N | Explain: | |
| Use of alcohol or drugs | ☐ Y | ☐ N | Explain: | |

Please list any additional medical history: _____

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# Family History

Have any family memebers had the following:

| | | | | |
|---|---|---|---|---|
| Deafness | ☐ Y | ☐ N | Who: | |
| Nasal allergies | ☐ Y | ☐ N | Who: | |
| Asthma | ☐ Y | ☐ N | Who: | |
| Tuberculosis | ☐ Y | ☐ N | Who: | |
| Heart disease (before age 50) | ☐ Y | ☐ N | Who: | |
| High blood pressure (before age 50) | ☐ Y | ☐ N | Who: | |
| Anemia | ☐ Y | ☐ N | Who: | |
| Bleeding disorder | ☐ Y | ☐ N | Who: | |
| Liver disease | ☐ Y | ☐ N | Who: | |
| Kidney disease | ☐ Y | ☐ N | Who: | |
| Diabetes (before age 50) | ☐ Y | ☐ N | Who: | |
| Bedwetting (after age 10) | ☐ Y | ☐ N | Who: | |
| Epilepsy or convulsions | ☐ Y | ☐ N | Who: | |
| Alcohol abuse | ☐ Y | ☐ N | Who: | |
| Drug abuse | ☐ Y | ☐ N | Who: | |
| Mental illness | ☐ Y | ☐ N | Who: | |
| Mental retardation | ☐ Y | ☐ N | Who: | |
| Immune problems, HIV or AIDS | ☐ Y | ☐ N | Who: | |

Please list any additional family history: _____

Signature of Patient/Responsible Party: _____

You may sign this document electronically through Adobe Acrobat Reader or if you prefer may sign it manually and fax to our office.